

#### DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection 103 South Main Street, Ladd Hall Waterbury, VT 05671-2306 http://www.dail.vermont.gov Voice/TTY (802) 871-3317

To Report Adult Abuse: (800) 564-1612

Fax (802) 871-3318

January 18, 2013

Ms. Claudette Werner-Poorman, Administrator Crescent Manor Care Ctrs 312 Crescent Blvd Bennington, VT 05201-0170

Provider #: 475033

Dear Ms. Werner-Poorman:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **December 19, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN Licensing Chief

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PC:ne

Enclosure



DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Jan 3 2013 11:02am P004

PRINTED:	01/03/2013
FORM	APPROVED
OMR NO	0938-0391

TATEMENT	OF DEFICIENCIES F CORRECTION	E & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475033	(X2) M A. BUII B. WIN		- COMPLE	URVEY RECEIVED Division of UAN 14 13 9/2012
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 312 CRESCENT BLVD BENNINGTON, VT 05201	CODE	Protection
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F 000	INITIAL COMMEN	NTS	F	000		
F 156 SS=D	was conducted by Protection between The following defit 483.10(b)(5) - (10	on-site recertification survey the Division of Licensing and en 12/17/2012 and 12/19/2012. ciencies were identified: ), 483.10(b)(1) NOTICE OF SERVICES, CHARGES	F	156		
	and in writing in a understands of hi regulations gover responsibilities du facility must also notice (if any) of the made prior to or unesident's stay.	Inform the resident both orally language that the resident is or her rights and all rules and ining resident conduct and uring the stay in the facility. The provide the resident with the he State developed under the Act. Such notification must be upon admission and during the Receipt of such information, and to it, must be acknowledged in				
	entitled to Medical of admission to the resident become items and services the which the resider other items and services and for which the amount of chainform each resider	inform each resident who is aid benefits, in writing, at the time he nursing facility or, when the is eligible for Medicaid of the est hat are included in nursing under the State plan and for int may not be charged; those services that the facility offers e resident may be charged, and arges for those services; and dent when changes are made to rvices specified in paragraphs (5) this section.				
	The facility must at the time of ad	inform each resident before, or mission, and periodically during ay, of services available in the				(X5) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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if continuation sheet Page 1 of 24

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FORM APPROVED

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	CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A BUILDING

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

		475033	B, WI	IG		12/19	9/2012
	ROVIDER OR SUPPLIER  NT MANOR CARE CT	RS	. <del>I</del> -	312	ET ADDRESS, CITY, STATE, ZIP CODE CRESCENT BLVD NNINGTON, VT 05201		
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TAG	Continued From paragraph facility and of charge including any charge under Medicare or The facility must fur legal rights which in A description of the personal funds, unsection;  A description of the for establishing elimited to request 1924(c) which determine the right to request 1924(c) which determines an equitate cannot be considered toward the cost of medical care in his down to Medicaid	ge 1 les for those services, les for services not covered by the facility's per diem rate.  In the awritten description of includes: In manner of protecting der paragraph (c) of this  In requirements and procedures gibility for Medicaid, including if an assessment under section for ermines the extent of a couple's for each attributes to the community for each attributes to the community for experiences which for experiences which for experiences of resources which for each available for payment for the institutionalized spouse's for her process of spending for eligibility levels.  The services is revices, for each covered for those services, for experiences and telephone		156	DEFICIENCY)		
	numbers of all per groups such as the agency, the State ombudsman prog- advocacy network unit; and a statem complaint with the agency concerning misappropriation facility, and non- directives required	e State survey and certification licensure office, the State ram, the protection and and the Medicaid fraud control tent that the resident may file a se State survey and certification g resident abuse, neglect, and of resident property in the compliance with the advance					

related to maintaining written policies and

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

		AND TOWAR SERVICES				OMB NO.	0938-0391
		& MEDICAID SERVICES	Lynn	LIS TICS!	E CONSTRUCTION	(X3) DATE S	
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F 156	Continued From pa	age 2 ing advance directives. These	F	156			
	requirements incluprovide written information about Medicare and Medicare and Medicare and Medicare arisisten information about Medicare arists includes a written policies to implem applicable State la The facility must in name, specialty, a physician responsional medicare and	de provisions to inform and ormation to all adult residents int to accept or refuse medical ent and, at the individual's an advance directive. This description of the facility's ent advance directives and			Resident # 56 remains in the facondition.  All residents and/or family will coverage of psychological servi. The Social Worker is responsit the resident and family unders aware of the coverage service.  Social Worker will complete raoutside services to assure that of coverage. Outcomes of audi presented to the CQI committe will be completed for two montcompliance.  2/5/13 On-going	be informed of ces upon referrole to assure that tand and are andom audits of family is informits will be see. These audits	al. t
	by: Based on record facility failed to er #56) of 23 identification what services we services under the resident may not services that the resident may or reinclude:  1. Per record revise.	review and staff interview the asure that 1 resident (Resident ed in the sample understood re included in nursing facility e State plan for which the be charged, those items and facility offers and for which the nay not be charged. The findings iew, Resident #56 was a facility on 8/3/12 with aclude dementia. Per review of			F156 POCaceepted 1/17/13 accerment Amc		

Facility ID: 475033

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CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 12/19/2012 475033 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 312 CRESCENT BLVD BENNINGTON, VT 05201 CRESCENT MANOR CARE CTRS PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 156 F 156; Continued From page 3 the medical record, Resident #56 indicated to ..... staff during an interview on 10/12/12 that Resident #56 thought he/she would be better off dead. The medical record also indicated that Resident #56 was verbally abusive at times and resistant to care. The medical record indicates Resident #56 sleeping for long periods of time and declining to participate in activities outside Resident #56's room. Per review of the physician's orders, an order was obtained by staff on 10/15/12 for Resident #56 to be evaluated by Deer Oakes for the need for possible psychological services for Resident #56 related to behavior issues (verbally abusive, resistant to care, and potential signs of depression). The nurses notes indicate that the spouse of Resident #56 declined the offer for psychological services because the spouse indicated to staff that he/she "did not want to pay for psychological services." Per a Physician fax order, the physician indicated to staff that the spouse "would not have to pay for psychological services that they would be covered by Medicare." Per review of the comprehensive plan of care, the behavior care plan indicates to utilize psychological services as needed. Per review of the medical record there was no evidence that nursing staff or staff in the Social Services department educated the spouse of Resident #56 regarding what services are covered by Medicaid and what services are the responsibility of the resident and there was no documentation that indicates the spouse of Resident #56 was educated on the possible need

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· DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
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F 156			F 156	·		
	they confirmed the staff during an in would be better confirmed that R at times and resist UM and SSD on was no documer in the Social Series spouse of Reside are covered by Mand the responsibility documentation the staff of th	nat Resident #56 had indicated to terview on 10/12/12 that he/she off dead. The SSD and UM also esident #56 was verbally abusive stant to care. Per interview the 12/19/12 confirmed that there station that nursing staff or staff vices department educated the ent #56 regarding what services Medicaid and what services are of the resident and there was no nat indicates the spouse of				
F 225 SS=D	Resident #56 was for psychological that he/she was Resident #56 wo psychological se covered by Medicomprehensive of that the facility was for psychological second that the facility was second to the facility was for psychological second to the facility was second	is educated on the possible need services. The SSD confirmed aware that the spouse of build not be expected to pay for rvices because they would be care. The UM confirmed that the care plan for behaviors indicated as to utilize psychological ded for Resident #56.  iii), (c)(2) - (4) REPORT	F 225			
	been found guilt mistreating resident had a finding en registry concern of residents or n and report any k court of law aga	not employ individuals who have y of abusing, neglecting, or lents by a court of law; or have tered into the State nurse aide ing abuse, neglect, mistreatment hisappropriation of their property; nowledge it has of actions by a inst an employee, which would is for service as a nurse aide or				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO: 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 12/19/2012 475033 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 312 CRESCENT BLVD CRESCENT MANOR CARE CTRS BENNINGTON, VT 05201 (X5) PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 225 F 225 | Continued From page 5 other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Past noncompliance: no plan of Based on record review and interviews, the correction required. facility failed to assure that two of four alleged violations of mistreatment or abuse in the sample (Resident #61 toward Residents #49 and #79) were thoroughly investigated and failed to prevent further abuse. Further, the facility failed to make a mandatory report of the abuse to Adult Protective Services or the State Survey and Certification Office through their established procedures and

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Facility ID: 475033

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 12/19/2012 475033 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 312 CRESCENT BLVD CRESCENT MANOR CARE CTRS BENNINGTON, VT 05201 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 225 F 225 Continued From page 7 thoroughly reviewed in an internal investigation. Both the Administrator and the DNS confirmed during this interview that neither the incident of 6/2/12, nor that of 6/4/12, had been reported to Adult Protective Services (APS) or the State Survey and Certification agency. The facility's written Administrative Policies & Procedures for Resident Abuse includes language requiring reports to APS for allegations of abuse, neglect, or exploitation within 48 hours of the incident, and outlines the steps of the required internal investigation. Based on investigation during the survey process, the facility corrected this deficient practice prior to the start of the recertification survey. F 242 483.15(b) SELF-DETERMINATION - RIGHT TO F 242 SS=D MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to to provide 1 resident of 2 (Resident #7) with the right to make choices about aspects of his/her life in the facility that are significant to the resident. The findings include: 1. Per direct observation during the noon meal on

12/17/12 at 12:24 PM in the main dining area on

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(X5) COMPLETION

DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 12/19/2012 475033 STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER

(X4) ID

PREFIX

TAG

#### CRESCENT MANOR CARE CTRS

312 CRESCENT BLVD

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

BENNINGTON, VT 05201

F 242	Continued From page 8
	the North wing. Resident #7 was eating lunch and
	requested from the Unit Manager (UM) to have
	more food. The UM indicated to Resident #7 that
	s/he could not have more food, that s/he was on
	Sine could not have more food, and of finished all
	a restricted diet and that s/he had not finished all
	the food in front of him/her yet. The UM indicated
	to Resident #7 to finish all his/her food and s/he
	O Resident #7 to milan an morner loss and

would be full. Per direct observation Resident #7 had pie, juice, milk and coffee in front of him/her to consume.

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

Per direct observation of Resident #7's dietary tray slip, Resident #7 had been served an omelet, pie, milk, coffee and cranberry juice for the lunch meal. The slip indicated that Resident #7 was on a 2200 calorie ADA (American Diabetic Association) diet. Per direct observation at 12:49 PM, Resident #7 again requested more food from the UM. The UM indicated to Resident #7 that s/he was on a "special diet" and the UM verbalized to Resident #7 that s/he would get him/her vegetables.

Per interview with Resident #7 on 12/17/12 at 12:41 PM, s/he indicated that s/he liked the food and that s/he wanted more and s/he could not get more.

Per interview with the UM and Dietary Consultant on 12/17/12 at 3:00 PM, they confirmed that Resident #7 was on a calorie restricted diet and that Resident #7 at each meal requests more food in addition to his/her normal meal. The Dietary Consultant indicated that they had worked with the physician to get a more liberal diet for Resident #7. The UM indicated that they had recently received orders from the physician to increase number of calories per day for Resident

F 242

PREFIX

TAG

Resident #7 remains in the facility in stable condition.

All residents have select menus to choose their likes and dislikes. All residents will be given choices related to their diet when asking for additional servings.

Staff Development will re-educate all staff on the importance of offering choices. Staff Development will complete dining room rounds to observe compliance.

Staff Development will complete audit of observations and report findings to the COI Committee for the next two months to assure compliance.

2/5/13 Fa42 POC occepted 1/19/13 GCOLEMANEN PMC

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F 242	prior to each meal	age 9 ent #7 is given a glass of water to fill him/her up, because the twant Resident #7 to consume	F 242				
	resident when Residench meal because to the physician or something healthy UM made the choosive him/her any of to eat. The UM are confirmed that Resident and that Resident and that Residence on 12/17/1 requested addition 483.15(g)(1) PRO RELATED SOCIATION The facility must preriods and that physicians of the services to attain of the services to attain the services the services to attain the services t	VISION OF MEDICALLY L SERVICE  rovide medically-related social or maintain the highest al, mental, and psychosocial	F 250				
	This REQUIREME by: Based on record facility failed to en appropriate social the needs of 1 of 1	ENT is not met as evidenced review and staff interview the sure that sufficient and services are provided to meet 23 residents reviewed (#56).					

Facility ID: 475033

. DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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B. WING 12/19/2012 475033 STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER

#### CRESCENT MANOR CARE CTRS

312 CRESCENT BLVD BENNINGTON, VT 05201

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F 250 Continued From page 10  re-admitted to the facility on 8/3/12 with diagnoses that include dementia. Per review the medical record, Resident #56 indicated the staff during an interview on 10/12/12 that Resident #56 thought s/he would be better of dead. Per review of the medical record, it indicated that Resident #56 was verbally about at times with staff and residents and resistancere. The medical record also indicates Resident #56 sleeps for long periods of time and decided to participate in activities outside his/her roce per review of the physician's orders, an ord obtained by staff on 10/15/12 for Resident #56 evaluated by Deer Oakes for the need for the record in the staff of the record in the rec	of to off usive int to sident lines om.	250		
possible psychological services related to vabusive behaviors, signs of possible depresand non compliance with care.  Per review of the nurses notes they indicate the spouse of Resident #56 declined the of psychological evaluation for Resident #56 because the spouse indicated to staff that "did not want to pay for psychological services of a Physician fax order dated"	e that ffer for he/she			
10/15/12 the physician indicated to staff the spouse of Resident #56 that he/she "would have to pay for psychological services (from Oakes) that the services would be covered Medicare."  Per review of the comprehensive plan of the behavior care plan indicates to utilize psychological services as needed.	m Deer			
Per review of the medical record there wa evidence that nursing staff or staff in the S Services department educated the spouse	social :		,	Page 11 of

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CRESCE	NT MANOR CARE C	TRS			ENNINGTON, VT 05201		
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F 250	covered by Medica responsibility of the documentation that Resident #56 was for psychological statement for facility staff durithat Resident #56 off dead. The SSE Resident #56 was staff and other respective with the confirmed that the nursing staff or statement educated and who of the resident to confirmed there windicates the spotential to receive psychological to pay the spouse of Respected to the spouse of Respected to the spouse of Respected to the spouse o	rding what is services are hid and what services are the eresident and there was no at indicates the spouse of educated on the possible need		250	Resident # 56 remains in the facility in strondition.  All residents and/or family will be informative to the coverage of psychological services upon the Social Worker is responsible to assume the resident and family understand and aware of the coverage service.  Social Worker will complete random au outside services to assure that family is of coverage. Outcomes of audits will be presented to the CQI committee. These will be completed for two months to assure compliance.  FASO POC Accepted 11713  GCOLEMOREN   PWK	med of referral. ure that l are udits of informed e e audits sure	:

F 279 483.20(d), 483.20(k)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS

> A facility must use the results of the assessment to develop, review and revise the resident's

confirmed that the comprehensive care plan for behaviors indicated that the facility was to utilize psychological services as needed for Resident

#56.

Total 3 7819 11 (flam P018/603

FRANCED 01/03/2910

PARTMENT OF HEALTH	AND HUMAN SERVICES			FORM OMB NO.	APPROVED 0938-0391
NTERS FOR MEDICARE EMENT OF DEFICIENCIES PLAN OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY
	475033	B. WING		12/1	9/2012
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plan for each reside objectives and time medical, nursing, needs that are ideassessment.  The care plan muto be furnished to highest practicable psychosocial well §483.25; and any be required undeast to the reside.	evelop a comprehensive care dent that includes measurable etables to meet a resident's and mental and psychosocial intified in the comprehensive st describe the services that are attain or maintain the resident's e physical, mental, and being as required under services that would otherwise in §483.25 but are not provided int's exercise of rights under githe right to refuse treatment	F 279			
by: Based upon rec the facility failed plans for 2 of 3 r objectives and ti medical, nursing that were identifi assessment rela (Resident #8) ar #56). Findings	ord review and staff interview, to develop comprehensive care esidents that include measurable metables to meet the resident's, mental and psychosocial need in the comprehensive and discharge planning (Residential discharge planning) (Residential discharge) and confirmed with the ing (DNS) on 12/19/12 at 12:50 are was not developed to address	ds ol			

8/14/12 to 11/28/12. Per review of the

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OMB NO. 0938-0391

DEPARTMENT (	FHEALTH AND HUMAN SERVICES
CENTERS FOR	EDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

475033

B. WING

A. BUILDING

12/19/2012

NAME OF PROVIDER OR SUPPLIER

#### CRESCENT MANOR CARE CTRS

STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD BENNINGTON: VT 05201

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

#### F 279 | Continued From page 13

comprehensive assessment, on 8/14/12 Resident #8 was continent of urine (able to control urinary discharge) and on 11/28/12 was occasionally incontinent of urine (unable to control urinary discharge). Per review of the "Continence Assessment" dated 7/6/12, Resident #8 was "Continent" and the "Continence Assessment" dated 11/27/12 indicates the current treatment plan is for "absorbent products - his/her preference". In addition, the "Continence Management Scoring Tool" dated 11/27/12 states Resident #8's Total Score is 11 and that a score of 6-11 indicates a candidate for toileting schedule (toileting schedule with incontinence care as needed).

2. Per record review on 12/19/12, Resident #56 was re-admitted to the facility with diagnoses that include dementia. Per review of the Social Service documentation dated 8/2/12, Resident #56 is to be admitted to the facility on 8/3/12 for Long term care placement on the dementia unit. Per the Social Service documentation dated 8/8/12 the family of Resident #56 indicated to staff that the drive to the facility from Brandon is too long and are requesting alternative placement in the Brandon area of Vermont. Per interview with the Unit Manager (UM) on 12/19/12, he/she indicated that Resident #56 was awaiting possible transfer to another facility related to increases in behavior issues.

Per review of the Comprehensive Admission Assessment (MDS) the disposition for Resident #56 indicates long term care placement. The MDS dated 11/6/12 indicates that the disposition F 279

#### F#279 Resident #8 is currently in the hospital and

expected to return.

The facility will use the Caretracker System "Continency Report". This report will be reviewed monthly by the Nurse Managers to audit and verify the accuracy of the Care Plan.

Outcomes of audits will be presented at the CQI Meeting. These audits will be completed for the next two months to assure accuracy. If compliance is not met the audits will continue.

2/5/13 On-going

> Resident # 56 remains in the facility in stable condition.

All Care Plans will be reviewed by the Staff Development Assistant to assure each resident has a documented discharge plan. MDS will assure that all plans are revised as needed. Staff Development Assistant will present outcomes to the CQI committee until compliance is met.

2/5/13

Fang POC accepted 1/17/13 GColeman RN/ PMC

Jan 3 2013 11:05am P018/028

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 279	Continued From p for Resident #56 is upon interview ind community.	age 14 s uncertain, that the resident icates a desire to return to the	F	27	79   		
	specific to the need developed discharged placement of Res	comprehensive care planeds of Resident #56, there is no rge care plan indicating the ident #56 to long term care with discharge Resident #56 to oser to family and for stated					
F 28 \$\$=	(SSD) and the UI confirmed that Re admitted to the far placement on the conversations will looking into alter facility that would family. The SSD needs for Reside planning were not developed care discharge needs to 483.20(d)(3), 48	the Social Service Director of on 12/19/12, the SSD esident #56 was originally acility for long term care and the family, the facility has been native placement in another be closer to Resident #56's confirmed that the the specific ent #56 regarding discharge of clear and that there was no plan to address Resident #56's and 10(k)(2) RIGHT TO PLANNING CARE-REVISE CP		F	280		
	The resident has incompetent or of incapacitated un participate in place changes in care.  A comprehensive within 7 days af	s the right, unless adjudged otherwise found to be nder the laws of the State, to anning care and treatment or	       				

Jan 3 2013 11:05am P019/028

PRINTED: 01/03/2013

FORM APPROVED OMB NO. 0938-0391

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDINĞ AND PLAN OF CORRECTION 12/19/2012 B. WING. 475033 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 312 CRESCENT BLVD BENNINGTON, VT 05201 CRESCENT MANOR CARE CTRS (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PRÉFIX DEFICIENCY) TAG F 280 F 280 Continued From page 15 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to review and revise the Plan of Care to reflect current needs for 2 of 23 residents (Resident # 56 & 48) The facility further failed to ensure that Resident #56 was allowed to participate in care planning or making changes in care and treatment. The findings include: Per record review, Resident #48, whose diagnoses include dementia with delusions, has a Plan of Care that includes: Risk for Falls and Injury related to poor safety awareness, unsteadiness, and history of falls. Per record review of Nursing Notes for Resident #48 and confirmed by the Charge Nurse on Resident #48's unit on 12/19/12 at 10:40 A.M., the resident experienced falls on 9/16/12, 10/20/12, and 12/16/12. Per record review, the facility's "Fall Prevention and Protocol Guidelines" states after a resident experiences a fall "Document the fall in the nursing notes and update the care plan". During the 12/19/12 interview, the Charge Nurse stated the resident's

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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(X2) MULTIPLE CONSTRUCTION A. BUILDING

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(X3) DATE SURVEY COMPLETED

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475033

B. WING

12/19/2012

NAME OF PROVIDER OR SUPPLIER

### CRESCENT MANOR CARE CTRS

STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD BENNINGTON, VT 05201

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

### F 280 ; Continued From page 16

Care Plan is to be reviewed/revised after each fall to assess the causes and implement interventions to prevent further falls. Then the review and/or the revision is recorded on the resident's Care Plan.

Per interview on 12/19/12 at 10:40 A.M., the Charge Nurse stated reviews or revisions should have but "were not done", and confirmed that there was no documentation on Resident #48's Care Plan for Risk of Falls and Injury, that indicated it had been reviewed or revised after each of the 3 separate falls.

2. Per Stage 1 interview with Resident #56 on 12/17/12, Resident #56 indicated that s/he was not able to participate in his/her care planning.

Per review of the medical record on 12/19/12, the Social Services (SS) notes dated 8/28/12 and the nursing notes dated 11/13/12, indicate that Resident #56's spouse attended care plan meetings to discuss care for Resident #56. Per review of the documentation there was no evidence in the nurses notes or Social Service notes that Resident #56 had been invited to participate in these meetings or that Resident #56 was invited but refused to participate in the care planning meetings.

Per review of the admission assessment dated 8/10/12, the assessment indicated that Resident #56 was oriented on admission. Review of the medical record indicated that Resident #56 has a diagnosis of dementia but was alert and oriented and able to make needs known. The review of

F 280

F #280 Resident # 48 remains in the facility in stable condition.

The Falls Committee reviews all falls. The Staff Development Coordinator will re-educate all Nursing Staff on the importance of documenting interventions to prevent falls on the Care Plan.

Nurse Managers will review care plans after the Falls Committee meeting to assure compliance. Outcomes will be presented to the CQI Committee.

2/5/13

Resident #56 remains in the facility in stable condition.

MDS Assistant will be responsible to invite each resident to the Care Conference. Documentation of attendance or refusal will be documented in the resident's record.

Random audits will be completed by Controller to assure compliance. Outcomes will be reported to the COI Committee.

2/5/13

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> (X5) COMPLETION

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES

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## CRESCENT MANOR CARE CTRS

STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD

(EACH CORRECTIVE ACTION SHOULD BE

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BENNINGTON, VT 05201

PROVIDER'S PLAN OF CORRECTION

F 280	Continued From page 17	!
	the admission paperwork indicates that Resident	:
	the admission paperwork indicates that resident	İ

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

the admission paperwork indicates that Resident #56 has a spouse involved in his/her care. There was no documentation in the medical record that Resident #56 has been deemed incompetent and unable to make own decisions regarding care.

Per interview with the Social Service Director (SSD) on 12/19/12, s/he confirmed that Resident #56 is able to make his/her own decisions regarding care. The SSD confirmed after review of the medical record documentation that there was no evidence that Resident #56 had been invited to participate in his/her care planning since admission on 8/3/12. Per interview the SSD indicated that s/he believes that Resident #56 had verbally been invited and refused to participate but was unable to provide documentation to verify this

3. Per direct observation on 12/19/12 from 0800 AM through 12:30 PM, Resident #56 was observed to not be utilizing his/her bilateral hearing aides.

Per review of the medical record, Resident #56 has bilateral hearing loss and needs to utilize bilateral hearing aides. Per review of the comprehensive care plan titled "Alteration in sensory-perception: vision and hearing", the staff is to "encourage regular use of bilateral hearing aides." Per review of the nurses notes there was no documentation that indicated that Resident #56 was being encouraged to utilize his/her hearing aides on a regular basis.

Per interview with the Licensed Practical Nurse (LPN) he/she indicated that Resident #56 had hearing aides. The LPN observed Resident #56

F 280

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TAG

Resident #56 remains in the facility in stable condition.

Residents who require hearing aids will be encouraged by staff to wear them.

Documentation of usage or refusal will be noted on the residents MAR/Treatment sheets.

To assure compliance audits will be completed by the Nurse Manager. To verify the documentation of usage or refusal. Outcome of audits will be presented to the CQI committee.

2/5/13

Facility ID: 475033

If continuation sheet Page 18 of 24

Jan 3 2013 11:06am P022/028

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DEPARTMENT OF HEALTH	AND HUMAN SERVICES		OMB NO. 0938-039
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	
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F 280 Continued From at 12:00 PM in that Resident hearing aides that Resident aides when [If the care plan plan indicated use of bilater.  Per interview 12/19/12 at a confirmed af notes did not Resident #56 aides. The Uncomprehens not been revision Resident #56 his/her bilated spouse is vitally per souse is vitally per sou	the activity room and confirmed #56 did not have his/her bilateral in his/her ears. The LPN indicated #56 "only wears [his/her] hearing his/her] spouse visits." Per review the LPN confirmed that the care of that staff is to encourage regular al hearing aides.  with the Unit Manager (UM) on approximately 2:00 PM, he/she her review of the nurses notes the reflect encouragement by staff for the care plan that the care plan having the care plan that the car	of  d fes F 282  ity of and in		

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F 282	survey, Resident in not receive anythin not receive anythin not receive anythin receive anythin receive anythin receive anythin not receive anythin not receive of the state o	m 12/17/12 during Stage 1 of the #56 indicated that he/she "diding to drink in-between meals."  medical record, Resident #56 is ation and has an order for Intake did and Output to be monitored. Increased a mursing assessment Resident int with meals.  comprehensive plan of care dittled "At risk for fluid volume Variable PO [by mouth] fluid plan indicates that Resident #56 and output monitored as courage PO fluid intake to at milliliters (ml) per 24 hours and a variety of fluids at regular		28	32		

Facility ID: 475033

Jan 3 2013 11:06am P024/028

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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- 44/42 (920ml) 12	2/14 (840m)), 12/15 (040111), 0115			İ		
40147140 (600m)	Resident #30 did 110t 1600140					
interprinal and	ant at tidid required in 24 nous - i					:
as per the care p	the purses notes or the intake					
Land Authorit detail	report that Resident #50 Hau					
been offered fluid	ds and refused them on 12/18,					:
12/14, 12/15 and	1 12/17/12.			!		
D indominar with	h the Unit Manager (UM) on					
140/40/42 the LIN	A confirmed that Kesidem #30					;
I was at simile for de	shudration and affer the UN	!				:
- reviewed the ca	re plan for Resident #30 nerside	;				
" D = . : J = ~ 456 ie	to have intake and output					
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Landaha badasi fr	ist Resident #30 was aware on in	ŧ				:
third chift and t	was consuming iluius. The Own					
confirmed afte	r review of the intake report that					:
	S FOR MEDICARE  OF DEFICIENCIES  CORRECTION  ROVIDER OR SUPPLIER  NT MANOR CARE CONTINUED FICIENCY REGULATORY OR  Continued From Five evidence that Reserved and supplied the following fluid 12/13 (820ml), 12/17/12 (600ml) the minimal amount as per the care of documentation in and output detail been offered fluid 12/14, 12/15 and Per interview wit 12/19/12, the UN was at risk for direviewed the care confirmed that the Resident #56 is monitored as indicated to a staff to offer a verification that the confirmed after 11/17 to 12/17/1/17 documentation consumption by no documentation fluids on the the 11/17/12 to 12/17/1/17/12 to 12/17/1/17/17/17/17/17/17/17/17/17/17/17/1	ROVIDER OR SUPPLIER  NT MANOR CARE CTRS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 20 evidence that Resident #56 refused fluids. The report also indicated that Resident #56 received the following fluid amounts in a 24 hour period 12/13 (820ml), 12/14 (840ml), 12/15 (840ml), and 12/17/12 (600ml). Resident #56 did not receive the minimal amount of fluid required in 24 hours as per the care plan (1000 ml). There was no documentation in the nurses notes or the intake and output detail report that Resident #56 had been offered fluids and refused them on 12/13, 12/14, 12/15 and 12/17/12.  Per interview with the Unit Manager (UM) on 12/19/12, the UM confirmed that Resident #56 was at risk for dehydration and after the UM reviewed the care plan for Resident #56 he/she confirmed that the care plan indicates that Resident #56 is to have intake and output monitored as indicated and encourage po fluid intake to at least 1000-1500 ml/24 hours and for staff to offer a variety of fluids at regular intervals throughout the day. Per interview the UM, he/she confirmed after review of the nurses notes from 11/17 to 12/17/12 that there was no documentation that staff had encouraged fluid consumption by Resident #56 and that there was no documentation in the Nurses notes from 11/17/12 to 12/17/12 that Resident #56 has refused any fluids that were offered. Per interview with the UM, he/she indicated that there was no documentation of staff offering Resident #56 fluids on the third shift during the time frame from 11/17/12 to 12/17/12 and the UM indicated that he/she knew that Resident #56 was awake on the third shift and was consuming fluids. The UM sonfirmed after review of the intake report that	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES F CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475033  ROWIDER OR SUPPLIER  NT MANOR CARE CTRS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 20  evidence that Resident #56 refused fluids. The report also indicated that Resident #56 received the following fluid amounts in a 24 hour period 12/13 (820ml), 12/14 (840ml), 12/15 (840ml), and 12/17/12 (600ml). Resident #56 did not receive the minimal amount of fluid required in 24 hours as per the care plan (1000 ml). There was no documentation in the nurses notes or the intake and output detail report that Resident #56 had been offered fluids and refused them on 12/13, 12/14, 12/15 and 12/17/12.  Per interview with the Unit Manager (UM) on 12/19/12, the UM confirmed that Resident #56 was at risk for dehydration and after the UM reviewed the care plan for Resident #56 he/she confirmed that the care plan indicates that Resident #56 is to have intake and output monitored as indicated and encourage po fluid intake to at least 1000-1500 ml/24 hours and for staff to offer a variety of fluids at regular intervals throughout the day. Per interview the UM, he/she confirmed after review of the nurses notes from 11/17 to 12/17/12 that there was no documentation that staff had encouraged fluid consumption by Resident #56 and that there was no documentation in the Nurses notes from 11/17/12 to 12/17/12 that Resident #56 has refused any fluids that were offered. Per interview with the UM, he/she indicated that there was no documentation of staff offering Resident #56 fluids on the third shift during the time frame from 11/17/12 to 12/17/12 and the UM indicated that he/she knew that Resident #56 was awake on the third shift and was consuming fluids. The UM	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES FORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A75033  ROVIDER OR SUPPLIER NT MANOR CARE CTRS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 20 evidence that Resident #56 refused fluids. The report also indicated that Resident #56 received the following fluid amounts in a 24 hour period 12/13 (820ml), 12/14 (840ml), 12/15 (840ml), and 12/17/12 (600ml). Resident #56 did not receive ithe minimal amount of fluid required in 24 hours as per the care plan (1000 ml). There was no documentation in the nurses notes or the intake and output detail report that Resident #56 had been offered fluids and refused them on 12/13, 12/14, 12/15 and 12/17/12.  Per interview with the Unit Manager (UM) on 12/19/12, the UM confirmed that Resident #56 was at risk for dehydration and after the UM reviewed the care plan for Resident #56 he/she confirmed that the care plan indicates that Resident #56 is to have intake and output monitored as indicated and encourage po fluid intake to at least 1000-1500 ml/24 hours and for staff to offer a variety of fluids at regular intervals throughout the day. Per interview the UM, he/she confirmed after review of the nurses notes from 11/17 to 12/17/12 that there was no documentation that staff had encouraged fluid consumption by Resident #56 and that there was no documentation in the Nurses notes from 11/17/12 to 12/17/12 that Resident #56 has refused any fluids that were offered. 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Resident had not met the daily requirement for fluid consumption of at least 1000 ml in a 24 hour

PRINTED:	01/03/2015
FORM.	APPROVED
OMB NO.	0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICE:	5
CENTERS FOR MEDICARE & MEDICAID SERVICES	<u>}</u>

STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

475033

B. WING

A. BUILDING

12/19/2012

NAME OF PROVIDER OR SUPPLIER

CRESCENT MANOR CARE CTRS

STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD

BENNINGTON, VT 05201

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 282 Continued From page 21

period on 12/13, 12/14, 12/15, and 12/17/12.

2. Per direct observation on 12/19/12 from 0800 AM through 1230 PM, Resident #56 was observed to not be utilizing his/her bilateral hearing aides.

Per review of the medical record, Resident #56 has bilateral hearing loss and needs to utilize bilateral hearing aides. Per review of the comprehensive care plan titled "Alteration in sensory-perception: vision and hearing", the staff is to "encourage regular use of bilateral hearing aides." Per review of the nurses notes there was no documentation that indicated that Resident #56 was being encouraged to utilize his/her hearing aides on a regular basis.

Per interview with the Licensed Practical Nurse (LPN) he/she indicated that Resident #56 had hearing aides. The LPN observed Resident #56 at 12:00 PM in the activity room and confirmed that Resident #56 did not have his/her bilateral hearing aides in his/her ears. The LPN indicated that Resident #56 "only wears his/her hearing aides when his/her spouse visits." Per review of the care plan the LPN confirmed that the care plan indicated that staff is to encourage regular use of bilateral hearing aides.

Per interview with the Unit Manager (UM) on 12/19/12 at approximately 2:00 PM, he/she confirmed after review of the nurses notes the notes did not reflect encouragement.by staff for Resident #56 to wear his/her bilateral hearing aides.

F 282

Resident #56 remains in the facility in stable condition.

1.

SDC will complete in-service to all nursing staff on the importance of documentation of fluid in takes. The Caretracker System Fluid Intake reports will be used to alert the Nurse Managers as to residents at risk for low fluid intake. Nurse Managers will address issues regarding low intakes. Compliance of documentation will be assured by audits completed by Nurse Managers and presented to the CQI Committee. These audits will continue for three months to assure documentation is completed.

....

2/3/13

Residents who require hearing aids will be encouraged by staff to wear them. Documentation of usage or refusal will be noted on the residents MAR/Treatment sheets.

To assure compliance audits will be completed by the Nurse Manager. To verify the documentation of usage or refusal. Outcome of audits will be presented to the CQI committee.

Jan 3 2013 11 Cfan F19473/8 34 W. C. C. B. Co. PRINTED: 01/03/2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 12/19/2012 475033 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 312 CRESCENT BLVD BENNINGTON, VT 05201 CRESCENT MANOR CARE CTRS (X5)PROVIDER'S PLAN OF CORRECTION COMPLETION SUMMARY STATEMENT OF DEFICIENCIES in (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC (DENTIFYING INFORMATION) TAG PREFIX DEFICIENCY) TAG F 282 F 282 Continued From page 22 3. Per review of the medical record, Resident #56 indicated to staff during an interview on 10/12/12 F250that Resident #56 thought he/she would be better off dead. The medical record also indicated that Resident # 56 remains in the facility in stable Resident #56 was verbally abusive at times with condition. staff and residents and resistant to care. The medical record indicates Resident #56 sleeps for All residents and/or family will be informed of coverage of psychological services upon referral. long periods of time and declines to participate in The Social Worker is responsible to assure that activities outside Resident #56's room. the resident and family understand and are aware of the coverage service. Per review of the physician's orders an order was obtained by staff on 10/15/12 for Resident #56 to Social Worker will complete random audits of be evaluated by Deer Oakes for the need for outside services to assure that family is informed possible psychological services related to verbally of coverage. Outcomes of audits will be abusive behaviors, signs of possible depression and non compliance with care.

> Per review of the nurses notes the notes indicate that the spouse of Resident #56 declined the offer for psychological evaluation for Resident #56 because the spouse indicated to staff that he/she "did not want to pay for psychological services." Per review of a Physician fax order dated 10/15/12 the physician indicated to staff that the spouse of Resident #56 that he/she "would not have to pay for psychological services (from Deer Oakes) that the services would be covered by

Per review of the comprehensive plan of care, the behavior care plan indicates to utilize psychological services as needed.

Per review of the medical record there was no evidence that nursing staff or staff in the Social Services department educated the spouse of Resident #56 regarding what is services are covered by Medicaid and what services are the presented to the CQI committee. These audits will be completed for two months to assure compliance.

F282 Poc occepted 1/17/13 G. Colemanen | Pmc

2/5/13 On-going

Medicare."

Carlo Situato en disa della 1799 ear 20, 24, 44 PRINTED: 01/03/2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING B. WING 12/19/2012 475033 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 312 CRESCENT BLVD CRESCENT MANOR CARE CTRS BENNINGTON, VT 05201 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 10 (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 282 F 282 | Continued From page 23

documentation that indicates the spouse of Resident #56 was educated on the possible need for psychological services.

The SSD confirmed that the comprehensive care plan for behaviors indicated that the facility was to

utilize psychological services as needed for

Resident #56.

responsibility of the resident and there was no

This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Crescent Manor Care Center does not admit that the deficiencies CMS2567 exist, nor does the facility admit to any statement findings, facts, or conclusions that form the basis for the alleged deficiency. The facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTERS I	FOR MEDICARE & MEDICAID SERVICES			"A" FORM				
	OF ISOLATED DEFICIENCIES WHICH CAUSE ITH ONLY A POTENTIAL FOR MINIMAL HARM ID NF3	PROVIDER # 475033	MULTIPLE CONSTRUCTION A. BUILDING B. WING	DATE SURVEY  COMPLETE: 12/19/2012				
NAME OF PROVIDER OR SUPPLIER CRESCENT MANOR CARE CTRS		STREET ADDRESS, CIT 312 CRESCENT BI						
		BENNINGTON, VI		4				
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIE	CIENCIES						
F 278	483.20(g) - (j) ASSESSMENT ACCU	RACY/COORDINATI	ON/CERTIFIED					
	The assessment must accurately reflect	the resident's status.						
	A registered nurse must conduct or cooprofessionals.	ordinate each assessmen	nt with the appropriate participation o	of health				
	A registered nurse must sign and certif	y that the assessment is	completed.					
	Each individual who completes a porti of the assessment.	on of the assessment m	ust sign and certify the accuracy of the	nat portion				
	Under Medicare and Medicaid, an indistatement in a resident assessment is statement; or an individual who willf false statement in a resident assessment assessment.	ubject to a civil money fully and knowingly cau	penalty of not more than \$1,000 for e ses another individual to certify a ma	each aterial and				
·	Clinical disagreement does not constitu	ute a material and false	statement.					
	This REQUIREMENT is not met as e Based on staff interview and record re- resident's status for 1 of 23 residents (F	view, the facility failed	to assure the assessment accurately r s include:	eflects each				
	1. Per record review of Nursing Notes unit on 12/19/12 at 10:40 A.M., the rereview of Resident #48's Minimum Da and Medicaid, states under 'Health Coi'Any [falls] since admission/entry/reer	sident experienced a fa ita Sheet (MDS) dated inditions - FALLS:	ll on 9/16/12 and again on 10/20/12. 10/27/12, required by the Centers for	Per record Medicare				
	Per interview with Resident #48's Chardocuments 2 falls between the MDS as Charge Nurse confirmed the MDS fall marked" on the 10/27/12 MDS but "we	ssessment on 7/27/12 as information was not a	nd the most recent MDS on 10/27/12	. The				

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If dofficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

"Figure Grant process of

DEPARTMENT OF HEALTH AND HUMAN SERVICES

"A" FORM

	OR MEDICARE & MEDICAID SERVICES							
STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFS AND NFS		PROVIDER # 475033	MULTIPLE CONSTRUCTION  A. BUILDING  B. WING	DATE SURVEY COMPLETE: 12/19/2012				
IAME OF PROVIDER OR SUPPLIER CRESCENT MANOR CARE CTRS		STREET ADDRESS, CIT 312 CRESCENT BL BENNINGTON, VI	.VD					
D		DZIII V						
refix ag	SUMMARY STATEMENT OF DEFICE	NCIES						
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED							
	The assessment must accurately reflect	et the resident's status.						
	A registered nurse must conduct or co professionals.	ordinate each assessme	nt with the appropriate participation o	of health				
	A registered nurse must sign and certi	fy that the assessment is	completed.					
	Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.							
	Under Medicare and Medicaid, an inc statement in a resident assessment is a assessment; or an individual who will false statement in a resident assessment.	subject to a civil money fully and knowingly cau	penalty of not more than \$1,000 for the last another individual to certify a magnification of the penalty of th	aterial and				
·	Clinical disagreement does not consti	itute a material and false	statement.					
	This REQUIREMENT is not met as Based on staff interview and record r resident's status for 1 of 23 residents	eview, the facility failed (Resident #48). Finding	gs include:					
	1. Per record review of Nursing Note unit on 12/19/12 at 10:40 A.M., the review of Resident #48's Minimum D and Medicaid, states under 'Health C'Any [falls] since admission/entry/residents	esident experienced a te Data Sheet (MDS) dated Onditions - FALLS:	III on $9/16/12$ and again on $10/20/12$ .	Medicare				
	Per interview with Resident #48's Ch documents 2 falls between the MDS Charge Nurse confirmed the MDS fa marked" on the 10/27/12 MDS but "	arge Nurse on 12/19/12 assessment on 7/27/12 a Ils information was not	at 10:40 A.M. Resident #48's medicand the most recent MDS on 10/27/12	al record 2. The				
	markod on the toran ta has a tur							
	marked on the 10/2/1/2 haze out							

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the state of the s